

OLD ETHICS: NEW DILEMMAS

by

WILLOUGHBY WILSON

Consultant Surgeon, Royal Victoria Hospital

Annual Oration at the opening of the 1981-82 Teaching Session, Royal Victoria Hospital, Belfast.

MEDICAL ethics may be described as a code of behaviour accepted voluntarily by the profession, as opposed to statutes and regulations imposed by official legislation. In many instances these are synonymous; for example, ethical matters constituting "infamous conduct" have for over a century been guarded by an official body, the General Medical Council. Numerous aspects of medical practice still fall outside official legislation but are none the less relevant to the doctor's behaviour and conscience, the limits being set by the approbation or disapproval of his colleagues. Much of medical ethics consists of good manners and civilised behaviour in the general sense, but there are certain matters which are peculiar to the practice of the profession of medicine. In Britain those aspects of medical behaviour which fall outside formal legislation are largely left to the conscience of the individual doctor: but the British Medical Association through its ethical committee has a particular interest in codifying, publicising and enforcing these ethical considerations upon its members.

The oldest code of medical ethics is the one well known to medical and lay persons alike, the Hippocratic Oath. Though now some twenty-five centuries old its basic tenets remain as valid as ever, but they are framed in archaic language and formulation, and however historically attractive have become anachronistic, leading to its restatement in the Declaration of Geneva. Formerly the Hippocratic Oath was pledged by new doctors at graduation ceremonies, but sadly this is now rare; even so the newly admitted practitioner still accepts its spirit and intentions. Following the gross transgression of medical ethics during the Second World War, the World Medical Association (at the instigation of the British Medical Association) reconstituted the Hippocratic Oath in modern style, this being known as the "Declaration of Geneva." Upon this, an international code of medical ethics was based. The Declaration of Geneva states:

"At the time of being admitted as a member of the medical profession, I solemnly pledge myself to consecrate my life to the service of humanity. I will give to my teachers the respect and gratitude which is their due. I will practice my profession with conscience and dignity. The health of my patients will be my first consideration. I will respect the secrets which are confided in me. I will maintain by all the means in my power the honour and noble traditions of the medical profession. My colleagues will be my brothers. I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient. I will maintain the utmost respect for human life from the time of conception. Even under threat, I will not use my medical knowledge contrary to the laws of humanity. I make these promises solemnly, freely and upon my honour."

A doctor must always maintain the highest standards of professional conduct. He must practice his profession uninfluenced by motives of profit. The following practices are deemed unethical:

1. Any self advertisement.
2. Collaboration in any form of medical practice in which the doctor does not have professional independence.
3. Receiving any money in connection with services rendered to a patient other than a professional fee.
4. Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest.

A doctor is advised to use great caution in divulging discoveries or new techniques of treatment. He should certify only to that which he has personally verified. He must always bear in mind the obligation of preserving human life and owes to his patient complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond his capacity he should summon another doctor who has the necessary ability. He should preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him. He must give emergency care as a humanitarian duty, unless he is assured that others are willing and able to give such care.

A doctor ought to behave to his colleagues as he would have them behave to him; he must not entice patients from them. Ethical behaviour is necessary right across the whole spectrum of medical practice, the overriding consideration being the welfare of the patient. It is easy to expand into prolix, pontifical generalisations about ethics, but it must be emphasised that ethical behaviour is a self imposed duty upon each doctor, and that no pride can be taken in behaviour calculated to avoid official censure, but which still remains professionally repugnant or undesirable.

The disapproval of ones colleagues should be at least as great a deterrent as the authority of courts of law, the General Medical Council or National Health Service Tribunals. Though reinforced by the presence of the General Medical Council, the terms of service of the National Health Service, and the ever present threat of civil action for negligence, the conduct of a doctor towards his patient is largely determined by his own feelings of professional responsibility, and awareness of ethical considerations. The well-being of the patient transcends any thought of financial advantage, convenience, or professional advancement. The patient is entitled to information about his illness, within limits determined by the doctor, who alone can see what measure of information should be disclosed. Conversely a doctor's strict duty to his patient is not to disclose such information to any other person except those properly entitled to receive it. Naturally the parents or guardians of small children are entitled to full disclosure, but as the age of a young person approaches sixteen the position alters, especially in regard to matters concerning pregnancy; the consent of a young person between sixteen to eighteen should be obtained before disclosure is made to the parents.

Part of the Hippocratic Oath affirms that "Whatever in connection with my professional practice, or not in connection with it, I see or hear in the life of men which ought not to be spoken of abroad, I will not divulge, as reckoning that all should be kept secret." Even if a medical graduate does not formally affirm this

oath on qualification he accepts its spirit and intention as an ideal standard of professional behaviour. Thus both on ethical grounds, and also because unwise breach of confidence may place him at the receiving end of a civil action, every practitioner should be careful of statements made outside the professional milieu.

The respect for such confidences obtained in a doctor patient relationship causes something of a conflict between law and ethics. There are situations where professional confidences may be broken. Where disclosure is to be anything but informal, such as to relatives, it is wise to obtain written consent. Notification of infectious diseases, certification of birth, death and various industrial diseases relating to public health must be disclosed. When requested to divulge information by a judge, magistrate or coroner, the doctor may demur, but continued refusal is at the risk of a fine or imprisonment for contempt of court. Where a doctor honestly believes that disclosure would be a breach of confidence he may request the court to respect his silence. All matters voiced in court are absolutely privileged and carry no risk of defamation or breach of confidence. The most difficult situation for the doctor is where his ethical inclination towards silence battles with his conscience concerning the welfare of the community. In some countries it is a statutory obligation to report to the police or other authorities any case of gunshot wounds or other evidence of possible criminal wounding seen by the doctor in the course of his practice. No such obligation exists in Britain and is left to the individual conscience of the doctor. This is very relevant in our present local society.

With the recent memories of human experimentation during the Second World War, and since then the great increase in clinical trials of new drugs and methods of treatment, the World Medical Association drew up a code of conduct known as the "Declaration of Helsinki." This states that it is the mission of the doctor to safeguard the health of the people. His knowledge and conscience are dedicated to the fulfilment of this mission, because it is essential that the results of laboratory experiments be applied to human beings to improve scientific knowledge and thereby help suffering humanity. The World Medical Association has prepared the following recommendations as a guide to each doctor in clinical research.

Clinical research must conform to the moral and scientific principles that justify medical research, and should be based on laboratory and animal experiments or other scientifically established fact. It should be conducted only by scientifically qualified persons and under the supervision of a qualified medical man. Clinical research cannot be legitimately carried out unless the importance of its objective outweighs the inherent risk to the subject. Special caution should be exercised by the doctor in performing clinical research in which the personality of the subject is liable to be altered by drugs or experimental procedures. In the treatment of the sick person the doctor must be free to use a new therapeutic measure if in his judgement it offers hope of saving life, re-establishing health or alleviating pain and suffering. The doctor can combine clinical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that clinical research is justified by its therapeutic value for the patient.

The greatest care should be taken when dealing with a patient, not to criticise or denigrate the professional ability of another doctor even by innocent implication. Differences of opinion over diagnosis and treatment are legitimate but should be conveyed in a way which would not undermine the patient's confidence in the other

doctor. This especially concerns the patient's referral by a general practitioner to hospital (where the outspokenness of a young doctor is often inversely proportional to the length of his experience). Where there is a marked difference of opinion it should be settled by direct contact between the two doctors, and not via the patient. Where a hospital doctor has been treating in hospital the patient of a general practitioner, there should be no undue extension of care after the patient has been discharged, and the patient should be returned to the care of the family doctor depending on the individual case and the complexity of the treatment. A doctor has no legal obligation to accept any patient for medical care unless directed to him under the tenure of service of the National Health Service. A private practitioner has no obligation to accept anyone whom he does not wish to treat. However, once accepted, his responsibility is absolute until such time as the relationship is ended either by voluntary withdrawal of the patient from treatment or withdrawal of the doctor from continued responsibility, which may only be done after due notice to the patient, and also the assurance that the patient has been accepted by another doctor. Until the latter event the first doctor is obliged to continue full responsibility. Naturally the death or distant removal of either party cancels this obligation. There are further statutory rules for general practitioners within the National Health Service, but these are not ethical matters.

Whereas it is the function of the courts to deal with the doctor who damages the patient, it is the function of the General Medical Council to deal with the doctor who damages his own profession. The General Medical Council was set up in 1858 to protect qualified medical practitioners from the competition of unqualified quacks and to protect the public by purging the profession of practitioners who offend against its own unwritten code of conduct. Unlike the courts the General Medical Council does not offer the patient with a grievance any personal redress; it does not award any damages but it does give the patient an opportunity to lodge a complaint against the professional conduct of a doctor.

The General Medical Council is composed of lay persons nominated by the Crown and by doctors elected by a postal vote of the profession. The majority are nominated by the universities conferring medical degrees, and by the Royal Colleges. Its functions are to deal with complaints and hold disciplinary hearings and also to maintain a Register of all those entitled to practise and to ensure that the educational standards of those qualifying for the profession are of an appropriate quality. The statutory duty of the General Medical Council is to deal with "serious professional misconduct" the elements of which have never been laid down formally. The concept has been described by a judge in 1894 as follows. "If a medical man in the pursuit of his profession has done something which will be regarded as disgraceful or dishonourable by his professional brethren of good repute and competency then it is open to the General Medical Council to say that he has been guilty of infamous conduct in a professional respect."

One of the main functions of the General Medical Council is to maintain the Medical Register where your name must be entered before you can practise. There is also a register of temporarily registered practitioners, mainly graduates from overseas training in this country. Inclusion in the Register is legal proof of a doctor's professional status, and confers upon him various legal benefits and responsibilities. Unless included in the Register he may not hold appointments in the National

Health Service, nor may he prescribe dangerous drugs, or treat certain cases of serious disease. Neither may he issue statutory certificates in respect of matters such as birth, death and cremation. He is also subject to the code of ethics and behaviour as decided by his professional colleagues acting through the Council. A doctor remains on the Register until death unless he fails to reply to the Registrar's enquiries or pay his retention fee, or ceases to engage in medical practice, or his name has been removed from the Register because of disciplinary erasure. A doctor can only practice while registered by the General Medical Council. Erasure from the Register prohibits him from carrying out any form of medical practice.

Though the potential reasons for erasure are limitless, the majority of cases arise from one of the six well known 'A's.

Abortion

The illegal termination of pregnancy has almost always been an immediate cause for erasure, even on the first occasion. Even following the reform in the law brought about by the Abortion Act of 1967, deliberate criminal abortion by doctors still occurs. It is imperative that all therapeutic abortions be carried out in the prescribed manner, with more than one doctor assenting to the decision, and that the procedure is performed openly in a proper institution.

Adultery

Any abuse of the doctor patient relationship which leads to adultery or other improper conduct or association with the patient, or with a member of the patient's family, carries a grave risk of erasure from the Register. Actual adultery need not be proven, if it is shown that an improper relationship exists beyond the permitted range of professional conduct.

Alcohol

Abuse of alcohol is one of the most common reasons for warnings, and if the offence is repeated, erasure from the Register may result. The most usual type of offence is drunken driving, although repeated convictions for "drunk and disorderly" or "drunk and incapable," have lead to erasure.

Addiction

Doctors, by virtue of their prescribing powers, have all too often fallen prey to addiction to therapeutic drugs, such as pethidine, morphine, heroin, and amphetamine. Anaesthetists have also been prone to addiction to cyclopropane, or nitrous-oxide. Apart from personal addiction, offences against the Dangerous Drugs Act in respect of irregularities in supply and records may form grounds for referral to the General Medical Council.

Association

This formerly was a common offence. It has now assumed much lesser importance, but consists of "covering" the activities of unqualified assistance. This was particularly common in midwifery work, where unqualified women were employed as midwives on behalf of the doctor. In an emergency, including childbirth, the assistance of an unqualified person would not now be held as "association."

Advertising

This position in regard to self advertisement or allowing others to proclaim his skill is one of the most confused aspects of this subject. It is unethical for any practitioner to perform or condone any form of publicity that draws attention to his professional merits, and thus possibly to attract new patients, and hence financial gain. It still remains a fact that compared to previous years when anonymity was absolute, the appearance of medical qualified persons on radio, T.V., and in newspaper articles is an almost everyday occurrence. The public have the right to be kept up to date with medical advice and opinion, but it is up to the individual practitioner as to what is ethical, and what is not. Canvassing for patients is quite wrong, whether done by word of mouth or written means.

The medical profession ought to have many high ideals and be above criticism. It cannot go very wrong if its members adhere to these ethics. The code of ethics has been subject to abuse by ill-informed non-medical people who do not understand that the code is designed, not to protect the profession, but to safeguard the interests of the patient. It is intended to cause all doctors to appreciate the privileged nature of their duties, to realise their responsibilities, and to treat their patients with fairness and humanity. It is meant to cause doctors to conduct their personal and professional relations as professional and personal relations ought to be conducted by gentlemen. When a doctor bears those principles in mind he is sure to remember that he is part of the best, the most charitable and the most ancient of professions, and that he follows a calling older than Christianity and more ancient than the Civil Law or the Welfare State.

Over one hundred and thirty years ago, the great, wise, eccentric and irascible John Abernethy, as he walked into a lecture room in St. Bartholomew's Hospital looked out upon the rows of medical students and said, half in curiosity, half in sorrow, "Good God, what is to become of you all." Today the same thought arises in the mind of your teachers. What will become of the students? All will die sooner or later, all will get more or less happiness and prosperity from the profession. Some will become rich, more will remain poor, a few will remain bachelors and spinsters, most will marry and breed children for good or ill. Some will get divorced, and a few will leave the profession. A few will become eminent, but the majority will not. In 1869 Sir James Paget endeavoured to think of a more specific answer to Abernethy's question. He traced the careers of a thousand pupils of St. Bartholomew's for fifteen years after graduation and concluded that about 10 percent of a class attain eminence or achieve considerable success. 50 percent will make a decent living, but it will be by strenuous effort. 20 percent will either do badly or fail utterly, about 10 percent will abandon practice and 10 percent will die. According to Paget's figures almost one third of any class of students make a mistake when choosing medicine as a profession. Paget's figures could apply today, that about the same proportion of a class will succeed and about the same proportion fail. It is discouraging to think that so many have little success, and that there are so many failures. Some of the failures would have succeeded in another occupation, and when they entered medicine spoilt a good business man, lawyer, accountant or farmer. When we see so many failures we naturally wish there was some infallible method whereby we might recognise the unfit, when they seek to start medicine, or early on in their student days so that they might avoid anguish. This would be good for medicine and for themselves.

How should we select medical students? Who are to be the judges and how do we assure that they are competent? It is certain that mere examination results cannot enable anyone to make a just decision. The world has a mania for examination results. The same is true of medical examinations. They are not tests of the man, they are tests of his memory for facts. They tell us little of his judgement, tact, energy, enthusiasm, idealism, reason, behaviour, temperament, disposition, honesty, loyalty, courage, truth, or intelligence. Memory for facts means little, but the other things mean all. Today some four thousand eight hundred students entered the Medical Schools of the United Kingdom, over one third of them being girls. Unsuccessful applicants numbered nearly fifteen thousand. The number of medical students has more than tripled since the late 1950's, when it was in the region of one thousand five hundred. The increase has been provided for largely by increasing the size of the medical schools, only three new ones having been established. The University of London contains twelve medical schools preparing medical students for the M.B. degree, two of these schools are clinical schools only, and two others offer courses in basic medical sciences. In England and Wales, there are thirteen medical schools outside London. There are five schools in Scotland, one of which is teaching basic medical sciences only. There is one school in Northern Ireland, and four in the Republic of Ireland. The responsibility for the standard of undergraduate medical education in all of these schools is vested in the General Medical Council. Since 1861, the General Medical Council has from time to time issued recommendations as to the aim, content, methods and duration of the medical school courses, and has power to inspect the examinations. Graduation has been synonymous with licence and referred to as qualification, although since 1953 a year of internship in an approved post has been required for full registration.

In the first half of this century, British medical schools gave sound instruction in available medical knowledge producing doctors well equipped to recognise the commonest clinical situations of the time and to deal with them in an acceptable fashion. However, as medicine began to change more rapidly, and rapidly to apply new scientific knowledge, it became clear that our education would have to be adapted to it. This has been changing continuously since the early fifties, but in an evolutionary rather than a revolutionary manner. Since the Royal Commission on Medical Education, the format of preparation for medicine has already changed and now consists of an undergraduate course, an internship, a period of vocational post-graduate training, and continuing education. In this context, the word 'vocational' is used in the sense of fitting the individual for his tasks. The medical course is no longer one of comprehensive coverage aiming to turn a schoolboy into a safe general practitioner. It has become a university course and there has been in all our medical schools a great strengthening of university staff and university facilities. The student has thereby become an undergraduate and no longer an apprentice.

In 1966, the Association for the Study of Medical Education showed that 60 percent of students approaching their final examination at the end of a five or six year course, had never performed a lumbar puncture, 70 percent had never washed out a stomach, 30 percent had never passed a catheter, and 50 percent had never measured a patient's blood count. Nearly two-thirds had never taken a decision which could have affected the course of a patient's illness. Indeed, between the age of eighteen on entry and twenty-three or twenty-four on graduation, most students have taken very few important decisions except in regard to marriage and voting.

Our students join medicine, almost all of them, because they want to help make sick people better. They want to make a positive interference in the course of illness in individual people. Most of our clinical teachers are engaged, predominantly and often exclusively, in that practice. This is the country which ignored Harvey's exhortation "To seek out the secrets of nature by experiment" and welcomed Sydenham as the father of English medicine. It was Sydenham who said that when the doctor approached the patient his mind should be empty of any hypothesis whatsoever, and, he should observe and record with the accurate detail of the miniature portrait painter. Our students spend long periods of time observing patients and recording their findings, presenting a written record of painstaking, orderly, arranged findings, and yet often are unable to write or say more than what would be the most practical thing to do next.

Medical students grow up in a situation in which, even despite recent changes, there is hardly any doubt as to precisely who is responsible for the patient and his care. Any recent trend towards the establishment of departments or services of a pyramidal structure has been superimposed on the time honoured and continuing fragmentation into as many independent autonomous units as there are members of consultant status. The British consultant has his own beds and clinics, his own groups of students and his own patients. This is not just a matter of personal responsibility. It is almost a matter of personal ownership. Each patient literally has his doctor's name stamped on him, on a band round his wrist as well as on his medical records. It would be difficult to imagine any setting more suitable for instruction in, and practice of clinical method, of a truly holistic approach to the individual, or any other roof under which is gathered such a comprehensive collection of every human hope or fear.

Good, effective, safe medical care of the individual patient must surely depend primarily on three things: Good clinical method, the ability to think critically and an abiding sense of responsibility to and for the patient. The doctor must think like the scientist, but be ready at any time in the interest of the patient to do what a scientist never does and a doctor must always do, i.e. to take action on inadequate data. The great changes in medical education have been partly the result of changes in medical practice but largely because of the aim to produce by education a doctor capable of thinking critically for himself like a scientist, whilst at the same time, training him to act like a doctor. This distinctive quality affects the doctors we produce. They are not identical with those we produced thirty or forty years ago nor are our students replicas of ourselves when we were young. This is fortunate because medicine has greatly changed. Paradoxically but very humanly, the public are inclined to explain the change in their doctors as being due to their lack of concern for people and a new scientific interest in disease. It is of course due to a new and more scientific understanding of people which the patients do not share. This separates doctor and patient who are further separated by the doctor's consciousness of medicine's vast ignorance and the patient's unshakable belief, so often shared by his relatives, that medicine is the panacea for all man's ills.

On graduation you must have your name placed on the Register of the General Medical Council paying a registration fee and annually a retention fee. Before commencing your preregistration year you must join a protection society, either the Medical Defence Union or Medical Protection Society to protect your employer and

yourself against litigation. Then you must work within the structure of the National Health Service which will be the employer of most of you for the rest of your professional lives. On graduation the first dilemma facing the young doctor is obtaining a preregistration post. With over production of medical graduates this is not always easy. On registration the choice of a specialty, which will give him a lifetime of rewarding and satisfying work no longer depends on his ambition, ability, intelligence or personality. Being forced to accept a post, often not in the specialty of his choice may produce a generation of unhappy, disgruntled and unfulfilled professionals. The relationship between the doctor and the State as his employer and controller of the public purse raises dilemmas.

The National Health Service is thirty-three years old; its original aspiration was to provide the best medical care for all and free for ever. After over thirty years its aspirations are being drowned by its imperfections. The deficiencies of the National Health Service are now familiar to all but have been cumulatively demoralising to those who provide primary health care, the doctor and the nurse. The shortcomings are not the work of fallible men that can be rectified by better men, but the unavoidable outcome of putting medicine into the political arena. At no time since the inception of the National Health Service has enough money been available to fulfil all the promises made by the politicians of a fully comprehensive service available to all and free at the point of contact. The disagreeable aspects of the National Health Service are a product of its subjugation to politics. Political decisions made at cabinet level now control the total expenditure on medical care in the National Health Service, less per capita than in every other western industrialised country. This has led to continuing irregularities between the social classes and regions, viz cardiac and orthopaedic surgery and renal failure; the emphasis on "caring" services for comfort to the relative neglect of "caring" to save life; the sacrifice of capital investment to current expenditure; the dominance of administration by producer interests and the persistence with state medicine even though many people would increasingly prefer a choice.

The so-called mixed economy is as essential to medicine as it is to trade and industry. State and private medicine must exist in symbiosis and not in competition. No country with an unstable economy can provide a fully comprehensive health service equally available for all its citizens, paid by normal taxation. Can the taxpayer afford two million non-emergency ambulance journeys a year when even the Merrison Royal Commission talks of National Health Service ambulances being used as "taxis"? Can we afford to spend almost as much on free sterilisation on demand carried out in National Health Service beds and individually paid for out of current expenditure as on dialysis machines for lack of which thousands of people die? Are eight million home visits by nurses and health visitors each year necessary when there is no money for CAT scanners or pace-makers? The reasons for these decisions are political because the politicians hold the purse-strings. The British citizen cannot, under the National Health Service get better medical advice or treatment for his family by paying more taxes and doctors and nurses have no inducement to advise their patients to demand more and better services because their life is made easier by inducing them to demand less.

Sadly the National Health Service has become less a service for the consumer than job creation for suppliers, administrators (who have increased by 53 percent since

reorganisation in 1973), cooks, cleaners, porters and ancillary staffs. This has led to a break-down of discipline, which must exist in a competitive world. Overtime payment for junior staff was imposed on the profession so that the new generation of doctors were brainwashed into believing that working in a hospital equated with clock-watching on the factory floor. The labour unions staged repeated strikes and instructions came from hospital administrators that the unions must not be opposed and that volunteer labour to care for the unfortunate patient was to be turned away. Mortuary attendants and grave-diggers refused to tend or bury the dead. By eliminating private care from public hospitals, the building unions were allowed to refuse to build private hospitals even when these had been planned and subscribed for by the local population. Acts such as these have done much to destroy the goodwill that should exist between the public and the medical and nursing professions. But the remedy is not in their hands. This rapid attempt at extreme socialisation has had the opposite effect to that intended, for as conditions in our hospitals have deteriorated, more and more people are turning to private medicine. Not only the middle class but the unions themselves in negotiating pay deals include private care in their demands so that our police force, engineers and some trade union bosses, even those in health service unions are now covered by private medical insurance. The full-time salaried service may become a clear disincentive to initiative, it also facilitates the introduction of overtime payments, and prevents the doctor from remaining a private individual contracting his service to the patient. For the first time ever in medicine, the problem of unemployment is almost upon us. A surplus of labour gives the employer, in this case the State, the whip hand in negotiating future terms of service. As in commercial life the availability of a product controls its price.

Friendship and family life apart, the three fundamental confidential relationships recognised by western society are those of man and priest, client and lawyer, and patient and doctor. No third party has yet entered into the first two relationships. There has entered into the relationship between doctor and patient a powerful, intrusive third party, the State. The conditions of medical practice within the National Health Service are now largely determined not by arrangement with the patient but by statute and administrative instruction. This immediately erodes all our old ethics. While the independence of the doctor's judgement in matters of medical advice, prescription and treatment is recognised and formally preserved, he is employed by a public agency and subjected to administrative and financial pressures originating not from his patient but from the Health Service and ultimately the State. The possibility of a conflict of the doctor's loyalties in today's society is a real one. The doctor has a duty to society. Situations occur in which the doctor may have to put the public interest before that of the patient, immediately contravening the Hippocratic Oath. It is an uncomfortable world for the doctor as he faces conflicts of loyalty and duty which he cannot avoid.

The possibility of this conflict is greatly enhanced by the technological achievements of modern medicine. The increasing need for, and development of team investigation and therapy in medical and surgical care reduce to a commonplace daily event the restoration of health in ways which were impossible a few years ago. But therapeutic progress involves increasing medico-legal dangers when doctors, technicians, nurses and other paramedical specialists share in a collective responsibility for a patient. It is inevitable that the team approach must

continue, and it is right that it should. But inherent litigation risks make it essential for the medical profession to give them due thought. Responsibility must be assessed and delegated in such a way that there is no avoidable weak link which could result in danger or disaster to the patient. In this situation the need to maintain the personal relationship of confidence between the patient and the doctor, and the healing motive represented by a largely anonymous team is very great indeed.

What is the principle which should govern the doctor's use of a life support machine? Is the prolongation of survival of the patient the overriding priority, or is he to regard as his first priority the devotion of his special skills and society's limited resources to the more rewarding task of treating those who can recover? The ethical solution to this dilemma has not yet been resolved and it is being made no easier by developments in the law governing damages for medical negligence. Negligence occurs when practice by any member of a medical team caring for a patient falls below the accepted standards of professional competence and training at that time. Health authorities are liable for any negligence in the treatment by those whom they have employed or engaged to provide it. It is now required by statute that in medico-legal cases arising within the National Health Service, the health authority be sued in the first instance with the medical team as secondary defendants. Medical negligence claims are increasing at an alarming rate. In the past two years indemnity payments made by the Medical Defence Union have increased by 36 and 48 percent respectively. The cost of litigation now intimidates neither the rich nor the poor but only the middle income group who do not receive free legal aid. There has been a steady increase in medical litigation since the inception of the National Health Service in 1948 and of free legal aid in 1949. Increasing medical negligence claims have been accompanied by a sensational increase in the damages now being awarded by the courts in personal injury cases. Awards are now reaching heights which represent a serious threat to the finances of health authorities and they must be a mounting cause of anxiety to the Medical Protection Societies and their customer, the doctor, who has to pay a premium. It is cold comfort for the doctor to be told that his skills and the life-support systems which medical technology now places at his disposal are potent factors increasing the amount of awards, but this is fact. It is much cheaper to kill than to disable, and it may be more merciful. This is the modern doctor's great dilemma.

These huge awards are available not only for medical accidents but for every case in which catastrophic injuries have been accidentally caused in circumstances imposing liability upon those accepting the medical care of the patient. Should the doctor officiously strive to keep alive a barely sentient human wreck? Does not death represent not only the humane alternative to the patient, but also the true interest of society? Does anybody stand to gain from survival? These attitudes create the risk of forcing the doctor to practice defensive medicine, an attitude which is inconsistent with the ethical duty owed by a doctor to his patient. We have seen in America the alarming increase in medical litigation giving rise to the practice of over elaborate and costly examinations of the patient and to "safe" treatment by which is meant safety for the doctor, the interest of the patient taking second place. If in Britain the costs of litigation increase, the pressure to practice defensive medicine may become overwhelming. In the context of defensive medicine the law certainly interferes with medical ethics. Defensive medical practice results from the increased likelihood of negligence claims against the doctor. As claims and settlements

increase the doctor may be forced to protect himself against society by carrying out unnecessary tests, some of which may in themselves carry a certain amount of risk and may not be medically justified. Negative defensive medical practice occurs when a doctor does not perform a procedure or operation which he regards as medically justified because of his fear that he may be sued for an untoward result occurring during the procedure. As a result the quality of care may be affected by the risk of litigation.

The law and society may claim that the threat of legal action has forced the medical profession to improve its standards, but this is true only if the law and society assumes that doctors are not dedicated people who care about their patients. Most doctors because of their own ethics, self-respect and human concern do not want a patient to be needlessly injured. Threats of legal action therefore do nothing to improve the doctor's attitude, and, in fact may have an adverse effect. Legal action may have an unhappy impact on both the medical profession and patients and may blur the distinction between good and bad, desirable and undesirable medical practices. Two factors bedevil ethics. First the intrusion, beneficent in many ways, of the State into the doctor patient relationship and second, technological advance. It is of great importance that the State should not directly or indirectly, dictate to the doctor the treatment to be given to his patient, and certainly the State should not determine when he is to turn off the life-support machine or pronounce the patient dead. It is also of great social importance that technological advance should not be allowed to extend indefinitely the existence of the irretrievably brain damaged patient. The ultimate dilemma is therefore death. The public must be made to realise that there are great social problems not only in the life support of the human vegetable but also in the survival of barely sentient people who cannot look after themselves. The species is *Homo sapiens*! May it not be weakened in its own fight for survival if it devotes strength and unlimited resources to maintain "Homo" when he is no longer "sapiens". The emotional burden on the relatives of a human wreck can be as heavy as the financial sacrifice. Is death to be considered only as the enemy of the human condition, is it not more properly to be seen as a necessary part of the human condition? Not an enemy but a friend without whose help mankind cannot survive.

Death when it comes should come with dignity. Savitier stated that disease, infirmity, and death are part of the human condition and in the end they will always have the last word against the doctor. Modern ingenuity has delayed death in some cases beyond what is fair to the patient, or just to society, Voltaire once said that the "Art of medicine consists of amusing the patient whilst nature cures the disease". The non-sapient patient is no longer amused, he is not capable of being entertained and nature which provides the final cure of death cannot reach the bedside. The determination of death is best left not to society but to the medical judgement of the doctors. Modern medical thinking suggests that an acceptable definition is the irretrievable disappearance of brain function.

To conclude, medicine must seek to minimise the social burden associated with the advances of our generation in the science and technology of human survival. It is a dilemma which the doctor by his own success has created and which he must strive to resolve in a way which is consistent with a proper respect for the life of every human being.